lazarspinalcare pc

We listen. We care. We get results.

New Patient Information

PEDIATRIC

Today's date: _____

Please complete the following information

Child's name: _____

Parent's name: _____

Address: _____

City, State, ZIP: _____

Home number: _____ Parent's work number: _____

Birth date: _____

Previous chiropractor: _____

Pediatrician: _____

Birth history

Labor and Delivery: ☐ Easy ☐ Moderate ☐ Difficult

Type of delivery: ☐ Vaginal delivery ☐ C-section ☐ Forceps/vacuum extraction

Regarding your child today

	Yes	No
Is your child accident prone?	☐	☐
Has your child had any falls down steps?	☐	☐
Has your child ever been involved in a motor vehicle accident?	☐	☐
Has your child ever been hospitalized or had surgery?	☐	☐
Has your child ever had any broken bones or sprain injuries?	☐	☐

What hurts and how long has it hurt?

1. _____
2. _____
3. _____
4. _____

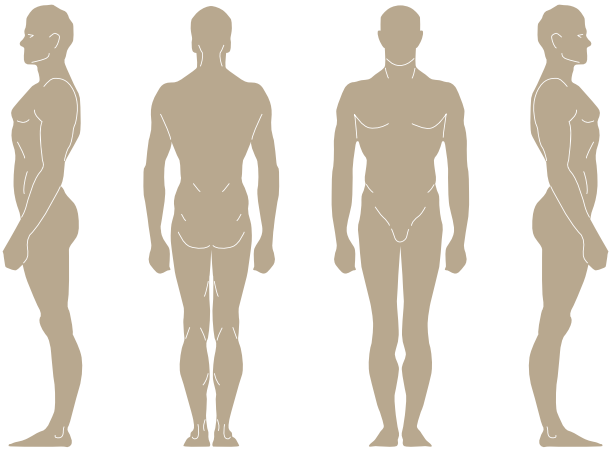
What Chiropractors or Medical Doctors have you consulted?

1. _____
2. _____
3. _____
4. _____

What do you think caused these problems?

1. _____
2. _____
3. _____
4. _____

Where are your child's problem areas?



Does your child experience any of these health problems?

☐ Headaches	☐ Learning disorder	☐ Ear infections	☐ Ear problems
☐ Menstrual problems	☐ Breathing problems	☐ Irritability	☐ Sinus pain/allergies
☐ Sleeping problems	☐ Underactive	☐ Asthma	☐ Eating disorder
☐ Fatigue	☐ Stomach problems	☐ Digestive trouble	☐ Hyperactivity
☐ Frequent colds	☐ Frequent flus	☐ Scoliosis	☐ Acne/rashes
☐ Diarrhea	☐ Constipation		

Terms of agreement

Due to changes in health insurance fees, patient self biling has become a much more cost effective way for you, the patient to get reimbursement for your care. Self biling allows us to keep our fees low so you can get the care you need without any added cost. Therefore, our policy is that all payment is due at the time of service and bills will not be sent to your insurance provider. Statements will be provided for you to submit on your own ensuring that as your insurance provider pays for your care, they will send the reimbursement check directly to you.

I attest that I am the parent / legal guardian of the minor mentioned above. I authorize Lazar Spinal Care, P.C. to render necessary services to my child and I am responsible for all charges incurred.

Parent/guardian signature: _____

Date: _____

Social security number: _____

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare/Insurance, your health information on this form may be shared with Medicare/Insurance. Your health information which Medicare/Insurance sees will be confidential.

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